U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 07 April 2005

CASE NO.: 2004-BLA-5044

In the Matter of

JIMMY BROWNING,
Claimant

v.

INDEPENDENCE COAL CO., LTD.,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Leonard J. Stayton, Esq.,
For the Claimant

Mary Rich Maloy, Esq. and Douglas Smoot, Esq.,
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a miner's claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*., as amended ("Act"), filed on February 11, 2002. The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,
3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal worker's pneumoconiosis" ("CWP")) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The claimant filed his claim for benefits on February 11, 2002. (Director's Exhibit 2 ("DX")). The claim was approved by the district director because the evidence established the elements of entitlement that Mr. Browning has coal workers' pneumoconiosis and is totally disabled due to pneumoconiosis. (DX 25). On July 16, 2003, the employer requested a hearing before an administrative law judge. (DX 27). On October 2, 2003, the case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Program (OWCP) for a formal hearing. (DX 32). I was assigned the case on February 27, 2004.

On August 3, 2004, I held a hearing in Charleston, West Virginia, at which the claimant and the employer were represented by counsel.[1] No appearance was entered for the Director, Office of Workman Compensation Programs (OWCP). The parties were afforded the full opportunity to present evidence and argument. Claimant's exhibits ("CX") 1-3, Director's exhibits ("DX") 1-34, and Employer's exhibits ("EX") 1, 2, 4-7, 11-12 were admitted into the record. [2]

Post-hearing evidence consists of the closing statements of both the claimant and the employer.

ISSUES[3]

I. Whether the miner has pneumoconiosis as defined by the Act and the Regulations?

II. Whether the miner's pneumoconiosis arose out of his coal mine employment?

III. Whether the miner is totally disabled?

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[1] Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(en banc), the location of a miner's last coal mine employment, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction. Under *Kopp v. Director, OWCP*, 877 F.2D 307, 309 (4th Cir. 1989), the area the miner was exposed to coal dust, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction.

[2] Dr. Wriot's *curriculum vitae* was admitted. The findings of the West Virginia Board were admitted, but not the objective test results.

[3] At the time of the hearing in this matter, the employer stipulated that the claimant was a miner within the meaning of the Act for at least four years. (TR 6). The employer further explained that it was not disputing that the claimant was employed in coal mine employment for a total of 15 years, but that the employer had no actual knowledge of that employment at the time of the hearing. Additionally, the employer had no knowledge regarding the dependency issue. (TR 7). However, the employer stated that after questioning the claimant, any dependency issues could be resolved. (TR 7). Therefore, these two issues were not disputed by the employer; however, the employer wanted to assure that adequate evidence pertaining to these issues had been presented. The evidence will be addressed in the applicable section of this Decision and Order although these two elements are not addressed in the Issues section of this Decision and Order.

IV. Whether the miner's disability is due to pneumoconiosis?

FINDINGS OF FACT

I. Background

A. Coal Miner[4]

The claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations, for at least 17 years. (DX 3 & 4). I find that the relevant evidence establishes that the claimant was a coal miner, within the meaning of the act for a period of at least 17 years.

B. Date of Filing

The claimant filed his claim for benefits, under the Act, on February 11, 2002. (DX 2). None of the Act's filing time limitations are applicable; thus, the claim was timely filed.

C. Responsible Operator

Independence Coal Co., Ltd. is the last employer for whom the claimant worked a cumulative period of at least one year and is the properly designated responsible coal mine operator in this case, under Subpart G for claims filed on or after Jan. 19, 2001, Part 725 of the Regulations. (TR 6).

D. Dependents

The claimant has three dependent for purposes of augmentation of benefits under the Act, his wife Kathy and his daughters Lora Beth and Jessica Ann. (DX 6, 7, 8 and 9; TR 10-12). All three live with the claimant and are dependent upon him for their support. (TR 12). The claimant's daughter Lora Beth is a full time student and his daughter Jessica Ann is disabled. (TR 11; DX 9). Therefore, I find that Kathy, Lora Beth and Jessica Ann are dependents of the claimant for the purposes of augmentation under the Act.

[4] Former subsection 718.301(a) provided that regular coal mine employment may be established on the basis of any evidence presented, including the testimony of a claimant or other witnesses and shall not be contingent upon a finding of a specific number of days of employment within a given period. 20 C.F.R. § 718.301 now provides that it must be computed as provided by § 725.101(a)(32). The claimant bears the burden of establishing the length of coal mine employment. *Shelesky v. Director, OWCP*, 7 B.L.R. 1-34 (1984). Any reasonable method of computation, supported by substantial evidence, is sufficient to sustain a finding concerning the length of coal mine employment. *See Croucher v. Director, OWCP,* 20 B.L.R. 1-67, 1-72 (1996)(en banc); *Dawson v. Old Ben Coal Co*., 11 B.L.R. 1-58, 1-60 (1988); *Vickery v. Director, OWCP*, 8 B.L.R. 1-430, 1-432 (1986); *Niccoli v. Director, OWCP*, 6 B.L.R. 1-910, 1-912 (1984).

E. Personal, Employment and Smoking History[5]

The claimant was born on January 2, 1949. (DX 2). He married Kathy, on February 8, 2002. (DX 6). The Claimant's last position in the coal mines was that of a roof bolter. (DX 2; TR 12).

He was employed in one or more underground mines for fifteen years or more. The claimant, as part of his duties, was required to "put up wire in the top," carry glue boxes weighing 40 pounds, perform "deadwork," lift rollers weighing up to 250 pounds with the help of one other person. (TR 13-15).

There is evidence of record that the claimant's respiratory disability is due, in part, to his history of cigarette smoking. The evidence is conflicting concerning the miner's smoking history. However, I find he smoked for 29 years at a rate of ½ pack per day and 2 years at a rate of one pack per day for a 16.5 pack year history. In his hearing testimony, the claimant testified that he smoked less than one pack per day for 29 years and a pack per day for 2 years. (TR 17-18). Dr. Ranavaya noted a smoking history that included smoking one pack per day for 33 years. (DX 11). Dr. Baker's smoking history notation indicates smoking for 34 years at a rate of less than one pack per day. (DX 23). The smoking history noted by Dr. Zaldivar is similar to Dr. Baker, noting smoking for 32 years at a rate of ½ pack per day. (EX 1). Dr. Crisalli indicated that the claimant smoked cigarettes for 27 years at a rate of ½ pack per day, with the claimant smoking one pack per day at the time of the examination. (EX 5).

I find that the claimant has a 16.5 pack year history. This finding is based on the smoking histories recorded in the record. With the exception of Dr. Ranavaya, all of the physicians of record note that the claimant smoked less than one pack per day for the bulk of the time that he smoked. This is supported by the claimant's testimony. Therefore, I have concluded that the claimant smoked at a rate of ½ pack of cigarettes per day for 29 years, followed by smoking one pack per day for 2 years. This leads to a smoking history equivalent to a 16.5 pack year history.

II. Medical Evidence[6]

A. Chest X-rays[7]

There are 11 readings of 4 X-rays, taken on December 15, 2003; August 5, 2003; February 5, 2003; and April 2, 2002. (DX 15, 16, 23 and 24; CX 1 and 2; EX 1, 4, 6 and 7). All of the readings are properly classified for pneumoconiosis, pursuant to 20 C.F.R. § 718.102(b).[8]

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[5] "The BLBA, judicial precedent, and the program regulations do not permit an award based solely upon smoking-induced disability." 65 Fed. Reg. 79948, No. 245 (Dec. 20, 2000).

[6] *Dempsey v. Sewell Coal Co. & Director, OWCP*, 23 B.L.R. 1-53, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004). BRB upheld regulatory limitations on the admissibility of medical evidence, under the new 2001 regulations, i.e., 20 C.F.R. Sections 725.414 and 725.456(b)(1).

[7] In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed. 20 C.F.R. § 718.102(e)(effective Jan. 19, 2001).

[8] ILO-UICC/Cincinnati classification of Pneumoconiosis – The most widely used system for the classification and interpretation of X-rays for the disease pneumoconiosis. This classification scheme was originally devised by the

Six are positive, by three physicians, Drs. Ranavaya, Baker, and Miller, who are B-readers, Board-certified in radiology or both.[9] Four are negative, by four physicians, Drs. Zaldivar, Scatarige, Willis and Wiot, all of whom are either B-readers, Board-certified in radiology, or both.[10] One reading was made for quality and abnormalities other than pneumoconiosis by Dr. Binns who is a B-reader and a Board-certified radiologist.

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation or Impression
CX 2	12/15/03 7/28/04	Miller	BCR/B	1	1/0; p/s	COPD; Congenital deformity with partial fusion of right first and second anterior ribs
EX 6	12/15/03 12/17/03	Willis	BCR/B	1	Negative	? emphysema; bony chest cage abnormality
CX 1	8/5/03 2/4/04	Miller	BCR/B	2	1/0; p/q	Definite emphysema; slightly calcified aorta right second rib deformity
EX 1	8/5/03 9/15/03	Zaldivar	BCI/B	1	Negative	Emphysema; congenital fusion of first and second ribs
EX 7	2/5/03 2/27/04	Wiot	BCR/B	2	Negative	? emphysema; bony chest cage abnormality
DX 24	2/5/03 4/10/03	Miller	BCR/B	2	1/0; p/s	Definite emphysema; aorta slightly calcified; slightly

International Labor Organization (ILO) in 1958 and refined by the International Union Against Cancer (UICQ) in 1964. The scheme identifies six categories of pneumoconiosis based on type, profusion, and extent of opacities in the lungs.

[9] *LaBelle Processing Co. v. Swarrow,* 72 F.3d 308 (3rd Cir. 1995) at 310, n. 3. "A "B-reader" is a physician, often a radiologist, who has demonstrated proficiency in reading x-rays for pneumoconiosis by passing annually an examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(1)(ii)(E); 42 C.F.R. § 37.51. Courts generally give greater weight to X-ray readings performed by "B-readers." *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n. 2 (7th Cir. 1993)."

[10] *Cranor v. Peabody Coal Co.,* 21 B.L.R.1-201, BRB No. 97-1668 (Oct. 29, 1999) *on recon*. 22 B.L.R. 1-1 (Oct. 29, 1999)(*En banc*). Judge did not err considering a physician's X-ray interpretation "as positive for the existence of pneumoconiosis pursuant to Section 718.202(a)(1) without considering the doctor's comment." The doctor reported the category I pneumoconiosis found on X-ray was not CWP. The Board finds this comment "merely addresses the source of the diagnosed pneumoconiosis (& must be addressed under 20 C.F.R. § 718.203, causation)."

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation or Impression
						deformed right second rib
DX 23	2/5/03 2/8/03	Baker	BCI(P)/B	2	1/0; p/p	Congenital anomaly right first rib
EX 4	4/2/02 10/1/03	Scatarige	BCR/B	2	Negative	Hyperinflation of lungs consistent with deep breath or emphysema – suggest clinical correlation; fusion anomaly of right first and second ribs; no evidence of coal workers' pneumoconiosis or silicosis
DX 24	4/2/02 4/10/03	Miller	BCR/B	2	1/0;p/s	Definite emphysema; aorta slightly calcified; slightly deformed right second rib
DX 16	4/2/02 7/15/02	Binns	BCR/B	1	Not classified for pneumoconiosis	Definite emphysema; right rib abnormality
DX 15	4/2/02 4/2/02	Ranavaya	BCI/B	1	1/0;p/q	Definite emphysema; fractured ribs

* A-A-reader; B-B-Reader; BCR – Board Certified Radiologist; BCP – Board-certified pulmonologist; BCI – Board-certified internal medicine; BCI(P) – Board-certified internal medicine with pulmonary medicine sub-specialty. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987) and, *Old Ben Coal Co. v. Battram,* 7 F.3d 1273, 1276 n. 2 (7th Cir. 1993). B-readers need not be radiologists.

**The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest X-ray classified as category "0," including subcategories "0/-, 0/0, 0/1," does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp*., 6 B.L.R. 1-307 (1983) (Under Part 727 of the Regulations) and *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 (June 19, 1997)(*en banc)(Unpublished)*. If no categories are chosen, in box 2B(c) of the X-ray form, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.

B. Pulmonary Function Studies[11]

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

Physician Date Exh. #	Age Height	FEV_1	MVV	FVC	Trac-ings	Compre-hension Coopera-tion	Qualify * Conform **	Dr.'s Impression
Crisalli 12/15/03 EX 5	54 72	2.32 2.44	72 Not in record	4.43 4.91	Yes	Not noted Not noted	Yes/Yes Yes	Moderate expiratory air flow obstruction; no restrictive defect; moderately severe air trapping; severe diffusion defect (hemoglobin corrected); no significant post-bronchodilator improvement
Zaldivar 8/5/03 EX 1	54 73	1.86 2.36	Not in record Not in record	4.28 5.28	Yes	Not noted Not noted	Yes/No Yes	Moderate reversible obstruction; air trapping by lung volume; moderate diffusion impairment
Baker 2/5/03 DX 23	54 72	1.99	Not in record	4.47	Yes	Fair Good	Yes Yes	Moderate obstructive defect
Ranavaya 10/3/02 DX 13[12]	53 73	2.16 2.36	Not in record Not in record	3.67 4.07	Yes	Good Good	No/No Yes	Nothing additional noted on report

[11] § 718.103(a)(Effective for tests conducted after Jan. 19, 2001 (See 718.101(b)), provides: "Any report of pulmonary function tests submitted in connection with a claim for benefits shall record the results of flow versus volume (flow-volume loop)." 65 Fed. Reg. 80047 (Dec. 20, 2000).

[12] This pulmonary function study was reviewed by Dr. Dominic Gaziano who found the testing to be of acceptable quality. Dr. Gaziano is Board-certified in pulmonary disease and internal medicine. (DX 14).

*A "qualifying" pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

** A study "conforms" if it complies with applicable standards (found in 20 C.F.R. § 718.103(b) and (c)). (*See Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 (7th Cir. 1993)). A judge may infer in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP,* 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

Appendix B (Effective Jan. 19, 2001) states "(2) the administration of pulmonary function tests shall conform to the following criteria: (i) Tests shall not be performed during or soon after an acute respiratory illness…"

Appendix B (Effective Jan. 19, 2001), (2)(ii)(G): Effort is deemed "unacceptable" when the subject "[H]as an excessive variability between the three acceptable curves. The variation between the two largest FEV_1'S of the three acceptable tracings should not exceed 5 percent of the largest FEV_1 or 100 ml, whichever is greater. As individuals with obstructive disease or rapid decline in lung function will be less likely to achieve the degree of reproducibility, tests not meeting this criterion may still be submitted for consideration in support of a claim for black lung benefits. Failure to meet this standard should be clearly noted in the test report by the physician conducting or reviewing the test." (Emphasis added).

For a miner of the claimant's height of 72.5 inches, § 718.204(b)(2)(i) requires an FEV_1 equal to or less than 2.36 for a male 53 years of age, and 2.34 for a male of 54 years.[13] If such an $FEV_{1\ is}$ shown, there must be in addition, an FVC equal to or less than 2.98 or 2.96, respectively or an MVV equal to or less than 94; or a ratio equal to or less than 55% when the results of the FEV_1 tests are divided by the results of the FVC test. The FEV_1/FVC ratio requirement remains constant.

C. Arterial Blood Gas Studies[14]

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange.[15] This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood, expressed in percentages, indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

[13] The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the tests are "qualifying." *Toler v. Eastern Associated Coal Co.*, 42 F.3d 3 (4th cir. 1995). I find the miner is 72.5" here, his average reported height.

[14] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.

20 C.F.R. §718.204(b)(2) permits the use of such studies to establish "total disability." It provides: In the absence of contrary probative evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii), or (iv) of this section shall establish a miner's total disability:…

(2)(ii) Arterial blood gas tests show the values listed in Appendix C to this part…

[15] 20 C.F.R. § 718.105(d)(Applicable Jan. 19, 2001) states:

"If one or more blood-gas studies producing results which meet the appropriate table in Appendix C is administered during a hospitalization which ends in the miner's death, then any such study must be accompanied by a physician's report establishing that the test results were produced by a chronic respiratory or pulmonary condition. Failure to produce such a report will prevent reliance on the blood-gas study as evidence that the miner was totally disabled at death."

Date Ex. #	Physician	PCO2	PO2	Qualify	Physician Impression
12/15/03 EX 5	Crisalli	43	77	No	Nothing noted on report
8/5/03 EX 1	Zaldivar	38 40*	73 75*	No	Mild hypoxemia unchanged with exercise; normal cardiopulmonary response to exercise
2/5/03 DX 23	Baker	39	76	No	Nothing noted on report
4/2/02 DX 12	Ranavaya	32 35.2*	75 93.5*	No	Nothing noted on report

*Results, if any, after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b).

Appendix C to Part 718 (Effective Jan. 19, 2001) states: "Tests shall not be performed during or soon after an acute respirator or cardiac illness."

D. Physicians' Reports[16]

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(A)(4). Where total disability cannot be established, under 20 C.F.R. § 718.204(b)(2)(i) through (iii), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b).

Dr. Robert J. Crisalli is Board-certified in internal medicine with a subspecialty in pulmonary disease. His examination report based upon his examination of the claimant, on December 15, 2003, notes 17.5 years of coal mine employment, with the most recent being in the position of a roof bolter and a 15-pack year smoking history. (EX 5). Dr. Crisalli described the claimant's symptoms as shortness of breath beginning in 2000, dyspnea on exertion and a productive cough.

[16] *Dempsey v. Sewell Coal Co. & Director, OWCP*, 23 B.L.R. 1-53, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004). Under the 2001 regulations, expert opinions must be based on admissible evidence.

Based on arterial blood gases, a pulmonary function study, and a negative chest X-ray interpretation by Dr. Willis, Dr. Crisalli diagnosed emphysema, asthma and hypertension. Dr. Crisalli opined that the claimant's pulmonary function testing revealed a moderate degree of obstruction to the claimant's expiratory airflow and a "moderately severe" degree of air trapping. Dr. Crisalli stated that this pattern is consistent with emphysema. Dr. Crisalli also believes that the testing included in the record and performed by other physicians indicates the presence of asthma. This is based on significant air trapping and some improvement when bronchodilators are administered.

The claimant's arterial blood gas testing at Dr. Crisalli's examination revealed a mild degree of hypoxemia. A carboxyhemoglobin test revealed continued "heavy" smoking. Dr. Crisalli did not find adequate evidence to justify a diagnosis of coal workers' pneumoconiosis or any chronic dust disease of the lungs "caused by, significantly related to or substantially aggravated by coal mine employment." Dr. Crisalli concluded that the claimant's testing is consistent with emphysema and asthma resulting from the claimant's smoking history.

In addressing the claimant's pulmonary impairment, Dr. Crisalli found that with "more aggressive asthma therapy" the claimant would be improved to the point where he would have no problem performing the duties required of him in his last job in the coal mine. Dr. Crisalli attributes all of the impairment suffered by the claimant to his asthma and emphysema that resulted from cigarette smoking.

Dr. George Zaldivar is a B-reader and is Board-certified in internal medicine, pulmonary disease, critical care medicine and sleep disorders. His examination report, based upon his examination of and review of the medical records of the claimant, on August 5, 2003, notes 17 years of coal mine employment and a 33-year smoking history at a rate of ½ pack per day. (EX 1). Dr. Zaldivar described the claimant's symptoms as shortness of breath, wheezing, productive cough and two pillow orthopnea.

Based on arterial blood gases, a pulmonary function study, and a negative chest X-ray, Dr. Zaldivar diagnosed asthma. Dr. Zaldivar found no radiographic evidence of pneumoconiosis. Additionally, Dr. Zaldivar found that the claimant exhibited a normal cardiopulmonary response to exercise, moderate reversible airway obstruction, air trapping and a moderate diffusion impairment. The carboxyhemoglobin test done at this time revealed the results of a current smoker smoking approximately one pack per day.

He opined that the claimant's pulmonary condition was not related to his coal dust exposure. Dr. Zaldivar found that the claimant's pulmonary impairment is a result of asthma that resulted from the claimant's smoking history. Dr. Zaldivar further opined that the decrease in the claimant's diffusing capacity is an "artificial result without any clinical consequences, given the normal resting and exercise blood gases." This is a result of smoking, according to Dr. Zaldivar.

In assessing the claimant's ability to return to his last coal mine employment, Dr. Zaldivar believes that if the claimant employed the use of bronchodilators, he could return to his last coal mine employment.

Dr. Glen Baker is a B-reader and is Board-certified in internal medicine with a subspecialty in pulmonary medicine. His examination report, based upon his examination of the claimant, on February 5, 2003, notes 17 ½ years of coal mine employment and a -34-year smoking history at a rate of less than one pack of cigarettes per day. (DX 23). Dr. Baker described the claimant's symptoms as daily sputum production, daily wheezing, dyspnea and cough.

Based on arterial blood gases, a pulmonary function study, and a positive chest X-ray, Dr. Baker diagnosed coal workers' pneumoconiosis, chronic obstructive pulmonary disease, hypoxemia and chronic bronchitis.

He opined that the claimant's pulmonary condition is related to his coal dust exposure. Dr. Baker bases his diagnosis of coal workers' pneumoconiosis on the claimant's chest X-ray results which show a 1/0 classification, as well as the claimant's exposure to coal dust. The claimant was also diagnosed by Dr. Baker as having chronic obstructive pulmonary disease which Dr. Baker attributes to the claimant's exposure to coal dust as well as his cigarette smoking history. Dr. Baker's diagnosis of hypoxemia is based on the claimant's PO_2 results and is caused by the claimant's coal dust exposure and cigarette smoking history. Lastly, Dr. Baker diagnosed chronic bronchitis which is based on the claimant's symptoms of cough, sputum production and wheezing. This condition, according to Dr. Baker is a result of the claimant's coal dust exposure and cigarette smoking history.

Dr. Baker described the claimant's pulmonary impairment as moderate. Dr. Baker believes that the claimant suffers from an occupational lung disease which was caused by the claimant's exposure to coal dust. Dr. Baker further believes that the moderate impairment suffered by the claimant is a result of both his coal dust exposure and cigarette smoking history. The claimant does not possess the respiratory capacity to perform his last coal mine employment or comparable work.

Dr. Mohammed Ranavaya is a B-reader and is Board-certified in occupational medicine. His examination report, based upon his examination of the claimant, on April 2, 2002, notes 27 years of coal mine employment and a 33-year smoking history at a rate of one pack of cigarettes per day. (DX 11). Dr. Ranavaya described the claimant's symptoms as sputum production, wheezing, dyspnea, productive cough, two pillow orthopnea, occasional paroxysmal nocturnal dyspnea and shortness of breath.

Based on arterial blood gases, a pulmonary function study, and a positive chest X-ray, Dr. Ranavaya diagnosed coal workers' pneumoconiosis, chronic obstructive pulmonary disease and hypertension.

He opined that the claimant's pulmonary condition is related to his coal dust exposure. Dr. Ranavaya attributes the claimant's coal workers' pneumoconiosis to his 27 years of coal mine employment and the claimant's chronic obstructive pulmonary disease to his cigarette smoking history. Dr. Ranavaya found the existence of a mild pulmonary impairment that would not prevent the claimant from performing his last coal mine employment.

IV. Witness' Testimony

Claimant, Jimmy Browning

The claimant testified at the time of the hearing in this matter. The claimant stated that he last worked for Independence Coal Company as a roof bolter. (TR 12). The claimant stopped working in the coal mining industry due to a shoulder injury. (TR 16). That claim is currently pending. (TR 17). The claimant has filed a Social Security Disability claim based on his shoulder injury and respiratory condition. (TR 17). In explaining his respiratory condition, the claimant stated that he is being treated by a pulmonologist and uses a nebulizer for treatment. (TR 20).

The claimant described his symptoms as including the inability to walk distances in excess of 80 feet without losing his breath. (TR 21). He also stated that he can stand for about 20 to 30 minutes before becoming short of breath. (TR 21). He also described having difficulty sleeping. (TR 22). His daily activities include spending time with his family and friends, but that he has had to give up his hobbies of bow hunting and fishing due to his shoulder injury. (TR 23).

Dr. George Zaldivar

Dr. Zaldivar was deposed in connection with his examination of the claimant on July 28, 2004. (EX 11). Dr. Zaldivar reviewed his findings from the August 2003 examination of the claimant and the histories and symptoms noted at that time. (EX 11, pp. 6-10). Dr. Zaldivar stated that the claimant is currently using only Albuterol for his lungs, which is a bronchodilator. (EX 11, p. 11). The doctor further stated that this particular medication would not be useful in the treatment of coal workers' pneumoconiosis because the obstruction caused by CWP does not respond to bronchodilator treatment because it is a fixed impairment. (EX 11, p. 11).

Dr. Zaldivar went on to discuss the claimant's chest X-ray which the doctor stated showed overinflation of the lungs indicating emphysema. (EX 11, p. 14). According to Dr. Zaldivar, the claimant's pulmonary function testing shows a reversible obstructive impairment with a change in the FVC value with the administration of a bronchodilator. (EX 11, p. 16). This does not indicate CWP to Dr. Zaldivar. (EX 11, p. 16). A carboxyhemoglobin test done at the time of the examination revealed the results of a close to one pack per day cigarette smoking habit. (EX 11, p. 21).

The claimant's blood gas testing did not worsen with the administration of exercise showing that the claimant is able to do a considerable amount of work. (EX 11, p. 23). Dr. Zaldivar opined that he believes Dr. Crisalli's report to be better reasoned than that of Dr. Baker because Dr. Crisalli reviewed all of the medical evidence in rendering his opinion. (EX 11, p. 26).

Dr. Zaldivar concluded that all of the testing of the claimant shows asthma. (EX 11, p. 27). Dr. Zaldivar attributes the claimant's impairment to asthma and the fact that the claimant is suffering from any impairment is because the asthma has gone relatively untreated. (EX 11, p. 28). This caused Dr. Zaldivar to opine that with proper medication, the claimant could perform

the duties of his last coal mine employment; however, without treatment, the claimant may suffer from a totally disabling respiratory impairment. (EX 11, p. 29). The severity of the impairment will vary due to the inherent nature of asthma, causing the claimant to have a mild impairment some days and have a very severe impairment some days. (EX 11, p. 29-30).

According to Dr. Zaldivar, coal dust exposure has played no role in the claimant's pulmonary condition. (EX 11, p. 30). The claimant's physical and clinical condition is a result of his smoking history which resulted in asthma. (EX 11, p. 30). This conclusion is based on the claimant's history, the carbon monoxide level in the claimant's blood, blood gas testing, and physical examination. (EX 11, p. 30-31). Dr. Zaldivar stated that asthma has never been linked to coal dust exposure, but that coal dust can aggravate someone already suffering from asthma. (EX 11, p. 35). Dr. Zaldivar concluded that the claimant does not suffer from any chronic dust disease of the lungs or any pulmonary impairment related to or aggravated by the claimant's exposure to coal dust. (EX 11, p. 35).

Dr. Robert Crisalli

Dr. Robert Crisalli was deposed in connection with his conclusions regarding the claimant on September 20, 2004. (EX 12). Dr. Crisalli reviewed his credentials and his practice focus. (EX 12, p. 4-6). Dr. Crisalli summarized the history and physical findings made at the time of his December 2003 examination of the claimant. (EX 12, pp. 8-13). Dr. Crisalli discussed the fact that the claimant is currently using Albuterol which Dr. Crisalli does not believe is helpful for the treatment of CWP. (EX 12, p. 14).

Dr. Crisalli did not review the claimant's chest X-ray himself, but did review Dr. Willis' interpretation of the claimant's chest X-ray. (EX 12, p. 15). Dr. Crisalli went on to discuss the claimant's pulmonary function testing which the doctor believes showed a moderate degree of obstruction with no significant improvement with the administration of bronchodilators. (EX 12, p. 16). There was no restrictive defect present. (EX 12, p. 17).

According to Dr. Crisalli, the most commonly seen pulmonary impairment with CWP is obstruction to airflow. (EX 12, p. 19). The claimant exhibits this condition but Dr. Crisalli does not believe that this is related to CWP. (EX 12, p. 19). The claimant also suffers from significant air trapping that Dr. Crisalli believes is contributed to by the claimant's asthma. (EX 12, p. 22-23). Dr. Crisalli also discussed the claimant's diffusion capacity results. These results were reduced related to the claimant's emphysema, according to Dr. Crisalli. (EX 12, p. 28).

Considering all of the claimant's pulmonary function testing, Dr. Crisalli opined that the testing showed an improvement after the administration of bronchodilators and variability in the results, leading Dr. Crisalli to conclude that the claimant suffers from asthma. (EX 12, pp. 32-33). These results are not seen with CWP. (EX 12, p. 33). The claimant has a significant history of coal dust exposure and a significant cigarette smoking history. (EX 12, p. 42). Dr. Crisalli's physical examination of the claimant showed no significant abnormalities to suggest the presence of any one disease. (EX 12, p. 43). The pulmonary function testing showed obstruction to airflow as a result of emphysema. (EX 12, p. 43). The finding of asthma is based on the exhibited reversibility and variability in the results. (EX 12, p. 43). Dr. Crisalli stated

that taking the chest X-ray results as a whole, there is no evidence of CWP, but does show emphysema. (EX 12, p. 43).

Dr. Crisalli opined that the evidence supports a finding of emphysema from smoking and the presence of asthma. (EX 12, p. 44). According to the doctor, coal dust exposure did not contribute to the claimant's asthma nor does the claimant suffer from occupational asthma. (EX 12, p. 44-45). Dr. Crisalli does not believe that either of these conditions has been aggravated by exposure to coal dust. (EX 12, p. 45). Dr. Crisalli also found the existence of an asthmatic bronchitis component to the claimant's condition; however, the doctor does not believe that this condition was related to, caused by or aggravated by exposure to coal dust. (EX 12, p. 46).

In assessing the claimant's disability status, Dr. Crisalli stated that the claimant's baseline could be disabling, but that the claimant has exhibited significant improvement with the administration of bronchodilators. (EX 12, p. 47). Dr. Crisalli again stated that with "aggressive therapy" to treat the claimant's asthma, the claimant could regain the pulmonary function necessary to perform his last coal mine employment. (EX 12, p. 47).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that: (1) he has pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and, (3) he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). *See Lane v. Union Carbide Corp.*, 105 F.3d 166, 170 (4th Cir. 1997). The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. *See Director, OWCP v. Mangifest*, 826 F.2d 1318, 1320 (3rd Cr. 1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP,* 9 B.L.R. 1-1 (1986). Moreover, "[T]he presence of evidence favorable to the claimant or even a tie in the proof will not suffice to meet that burden." *Eastover Mining Co. v. Director, OWCP [Williams]*, ___ F.3d ___, No. 01-4064 (6th Cir. July 31, 2003), *citing Greenwich Collieries [Ondecko]*, 512 U.S. 267 at 281; *see also Peabody Coal Co. v. Odom*, __ F.3d ___, 2003 WL 21998333 (6th Cir. Aug. 25, 2003)(Credit treating physician on more than mere status).

B. Existence of Pneumoconiosis

Pneumoconiosis is defined as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b) and 20 C.F.R. § 718.201. The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201.[17]

[17] Regulatory amendments, effective January 19, 2001, state:

The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[18] Thus, "pneumoconiosis", as defined by the Act, has a much broader legal meaning than does the medical definition.

"…[T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing, Rose v. Clinchfield Coal Co.*, 614 F.2d 936, 938 (4th Cir. 1980).

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995) and *see* § 718.201(a)(2).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by:[19] (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a)(1); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the

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(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure. (Emphasis added).

[18] The definition of pneumoconiosis, in 20 C.F.R. section 718.201, does not contain a requirement that "coal dust specific diseases …attain the status of an "impairment" to be so classified. The definition is satisfied "whenever one of these diseases is present in the miner at a detectable level; whether or not the particular disease exists to such an extent as to become compensable is a separate question." Moreover, the legal definition of pneumoconiosis "encompasses a wide variety of conditions; among those are diseases whose etiology is not the inhalation of coal dust, but whose respiratory and pulmonary symptomatology have nevertheless been made worse by coal dust exposure. *See, e.g., Warth*, 60 F.3d at 175." *Clinchfield Coal v. Fuller*, 180 F.3d 622 (4th Cir. June 25, 1999) at 625.

[19] 20 C.F.R. § 718.305 creates a rebuttable presumption of pneumoconiosis under certain facts for claims filed before Jan. 1, 1982. 20 C.F.R. § 718.306 establishes a presumption of entitlement applicable to certain death cases where the miner died on or before Mar. 1, 1978.

irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.[20] 20 C.F.R. § 718.202(a)(4).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is contrary to the Board's view that an administrative law judge may weigh the evidence under each subsection separately, i.e. x-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the court cited to the Third Circuit's decision in *Penn Allegheny Coal co. v. Williams,* 114 F.3d 22, 24-25 (3d Cir. 1997) which requires the same analysis.

The claimant cannot establish pneumoconiosis pursuant to subsection 718.202(a)(2) because there is no biopsy evidence in the record. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable to a living miner's claim filed after January 1, 1982, with no evidence of complicated pneumoconiosis.

A finding of the existence of pneumoconiosis may be made with positive chest X-ray evidence. 20 C.F.R. § 718.202(a)(1). The correlation between "physiologic and radiographic abnormalities is poor" in cases involving CWP. "[W]here two or more X-ray reports are in conflict, in evaluating such X-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays." *Id.; Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985)." (Emphasis added). (Fact one is Board-certified in internal medicine or highly published is not so equated). *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991) at 1-37. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985).

A judge is not required to defer to the numerical superiority of x-ray evidence, although it is within his or her discretion to do so. *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-70 (1990) citing *Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990). This is particularly so where the majority of negative readings are by the most qualified physicians. *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co. & Director, OWCP,* 16 B.L.R. 1-31, 1-37 (1991).

There are 11 readings of 4 X-rays, taken on December 15, 2003; August 5, 2003; February 5, 2003; and April 2, 2002. (DX 15, 16, 23 and 24; CX 1 and 2; EX 1, 4, 6 and 7). Six

[20] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel,* 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented" (medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

are positive, by three physicians, Drs. Ranavaya, Baker, and Miller, who are B-readers, Board-certified in radiology or both. Four are negative, by four physicians, Drs. Zaldivar, Scatarige, Willis and Wiot, all of whom are either B-readers, Board-certified in radiology, or both. One reading was made for quality and abnormalities other than pneumoconiosis by Dr. Binns who is a B-reader and a Board-certified radiologist.

Since the most recent X-ray (12/15/03) was read as both positive and negative by equally qualified readers, I would ordinarily find it in equipoise. However, given my findings that the earlier X-rays are positive, I find Dr. Miller's positive reading more persuasive. I find the consistently positive ("1/0") readings by dually-qualified Dr. Miller most persuasive. Two of his readings are corroborated by B-readers, Drs. Baker and Ranavaya. The 8/5/03 X-ray was read by only one dually-qualified reader, versus a B-reader, and thus, I find it positive. Nearly all the readers agree the X-rays show emphysema.

I find that the claimant has established the existence of pneumoconiosis by a preponderance of the chest X-ray evidence.

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative X-ray. 20 C.F.R. § 718.202(a).

Medical reports which are based upon and supported by patient histories, a review of symptoms and a physical examination constitute adequately documented medical pinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contradicts it.[21] *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Physician's qualifications are relevant in assessing the respective probative value to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Because of their various Board-certifications, B-reader status, and expertise, as noted above, I find that all of the physicians of record are equally qualified to offer opinions in this matter.

As a general rule, more weight is given to the most recent evidence because pneumoconiosis is a progressive and irreversible disease. *Stanford v. Director, OWCP*, 7 B.L.R. 1-541 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-166 (1983); and, *Call v. Director,*

[21] *Fields v. Director, OWCP*, 10 B.L.R. 1-19, 1-22 (1987). "A 'documented' (medical) report sets forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis. A report is 'reasoned' if the documentation supports the doctor's assessment of the miner's health. *Fuller v. Gibraltor Coal Corp.*, 6 B.L.R. 1-1291 (1984)…"

OWCP, 2 B.L.R. 1-146 (1979).[22] This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984).

It is rational to credit more recent evidence, solely on the basis of recency, only if it shows the miner's condition has progressed or worsened. The court reasoned that, because it is impossible to reconcile conflicting evidence based on its chronological order if the evidence shows that a miner's condition has improved, inasmuch as pneumoconiosis is a progressive disease and claimants cannot get better, "[e]ither the earlier or later result must be wrong, and it is just as likely that the later evidence is faulty as the earlier…" *Adkins v. Director, OWCP*, 958 F.2d 49, 16 B.L.R. 2-61 (4th Cir. 1992). *See also, Thorn v. Itmann Coal Co.,* 3 F.3d 713, 18 B.L.R. 2-16 (4th Cir. 1993).

Drs. Ranavaya and Baker found the existence of pneumoconiosis based on the claimant's chest X-rays as well as his exposure to coal dust. (DX 11 and 23). Their opinions are well-reasoned and based on the objective medical evidence contained in the record in this matter. Drs. Zaldivar and Crisalli found the existence of asthma and emphysema as a result of the claimant's significant smoking history. (EX 1 and 5). These opinions are also well-reasoned and based on the objective medical evidence contained in the record.

All four physicians examined the claimant and had access to the claimant's medical history. However, they have come to reach differing conclusions regarding the claimant's condition. Both Dr. Baker and Dr. Ranavaya found COPD, of which emphysema is an element. Dr. Baker attributed it to both coal mine dust exposure and smoking. Dr. Ranavaya attributed the COPD/emphysema to smoking, but he is not a pulmonologist like Dr. Baker. Drs. Crisalli and Zaldivar likewise both found a moderate obstructive impairment, which they attributed to emphysema due to smoking and asthma. Dr. Baker also attributed the miner's chronic bronchitis and hypoxemia to both smoking and coal dust exposure. Given the fact three equally-qualified specialists limited the cause of the COPD/emphysema solely to smoking; I give Dr. Baker's etiology conclusion less credit and do not find legal pneumoconiosis. However, the clinical CWP findings by Drs. Baker and Ranavaya are supported by the positive X-ray readings, unlike the diagnoses of Drs. Crisalli and Zaldivar. Moreover, it appears Dr. Crisalli relied primarily on the negative X-ray reading by Dr. Willis, thus not giving appropriate credit to the majority of positive readings.

A general disability determination by a state or other agency is not binding on the Department of Labor with regard to a claim filed under Part C, but the determination may be used as some evidence of disability or rejected as irrelevant at the discretion of the fact-finder.[23] *Schegan v. Waste Management & Processors, Inc.*, 18 B.L.R. 1-41 (1994); *Miles v. Central Appalachian Coal Co.*, 7 B.L.R. 1-744 (1985); *Stanley v. Eastern Associated Coal Corp.*, 6 B.L.R. 1-1157 (1984) (opinion by the West Virginia Occupational Pneumoconiosis Board of a

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[22] *Cranor v. Peabody Coal Co.*, 21 B.L.R. 1-201, BRB No. 97-1668 (Oct. 29, 1999) *on recon*. 22 B.L.R. 1-1 (Oct. 29, 1999)(*En Banc.*). In *Clark v. Karst-Robbin Coal Co*., 12 B.L.R. 10-149 (1989), the Board holds greater weight may be accorded to more recent X-ray evidence of record. In *Abshire*, the Board also recognized *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 11 B.L.R. 2-1 (1987) (CWP is a progressive disease).

[23] See § 718.206 "Effect of findings by persons or agencies." (65 Fed. Reg. 80050, Dec. 20, 2000) (Effective Jan. 19, 2001). If properly submitted, such evidence shall be considered and given the weight to which it is entitled as evidence under all the facts before the adjudication officer in the claim.

"15% pulmonary functional impairment" is relevant to disability but not binding). *McMath v. Director, OWCP,* 12 B.L.R. 1-6 (1988).

I have admitted the findings of the West Virginia Occupational Pneumoconiosis Board without the supporting medical documentation. (EX 2, TR 33). The Board found no evidence of pneumoconiosis and denied the claimant benefits. I have afforded this opinion the appropriate weight considering the limited purpose for which it was admitted.

I have weighed all of the evidence pertaining to the existence of pneumoconiosis together, as required by *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000), and find that the claimant has established the existence of pneumoconiosis by a preponderance of the evidence. I find the claimant has met his burden of proof in establishing the existence of pneumoconiosis. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994) *aff'g sub. nom. Greenwich Collieries v. Director, OWCP,* 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

C. Cause of Pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).[24]

Since the miner had ten years or more of coal mine employment, the claimant receives the benefit of the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. Nor is there evidence establishing that his pneumoconiosis arose out of coal mine employment from causes other than coal mine dust exposure.

D. Existence of total disability due to pneumoconiosis

The claimant must show his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b).[25] Section 718.204(b)(2)(i) through (b)(2)(iv) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with

[24] Specifically, the burden of proof is met under § 718.203(c) when "competent evidence establish[es] that his pneumoconiosis is significantly related to or substantially aggravated by the dust exposure of his coal mine employment." *Shoup v. Director, OWCP,* 11 B.L.R. 1-110, 1-112 (1987).

[25] § 718.204 (Effective Jan. 19, 2001). Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis, states: (a) General. Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis, or who were totally disabled due to pneumoconiosis at the time of death. For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease shall be considered in determining whether a miner is or was totally disabled due to pneumoconiosis.

qualifying values; (iii) evidence that miner has pneumoconiosis and suffers from cor pulmonale with right-side congestive heart failure; (iv) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and lay testimony.[26] Under this subsection, the Administrative Law Judge must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on reconsideration en banc*, 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. Section 718.204(d) is not applicable because it only applies to a survivor's claim or deceased miners' claim in the absence of medical or other relevant evidence.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718. More weight may be accorded to the results of a recent ventilatory study over those of an earlier study. *Coleman v. Ramey Coal Co.,* 18 B.L.R. 1-9 (1993).

There are four pulmonary function tests included in the record in this matter. Two of the tests have both pre- bronchodilator and post-bronchodilator results. Four of the test results (in the three most recent tests) produced values that qualify under the applicable Regulations. Three of the results do not qualify. Based on the foregoing, I find that the claimant has established the existence of a totally disabling pulmonary impairment by a preponderance of the pulmonary function tests.

Claimants may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. § 718.204(b)(2)(ii).

None of the four arterial blood gas tests produce values that qualify under the applicable Regulation. Therefore, the claimant has failed to establish the existence of a totally disabling respiratory impairment by a preponderance of the arterial blood gas test results.

Finally, total disability may be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medial judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition presents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable or gainful work. § 718.204(b). Under this subsection, "…all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element."

[26] In a living miner's claim, lay testimony "is not sufficient, in and of itself, to establish disability." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994). See 20 C.F.R. § 718.204(d)(5)(living miner's statements or testimony insufficient alone to establish total disability)

Mazgaj v. Valley Coal Company, 9 B.L.R. 1-201 (1986) at 1-204.[27] The fact finder must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP,* 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work a *prima facie* finding of total disability is made and the burden of going forward with evidence to prove the claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined pursuant to 20 C.F.R. § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

I find that the miner's last coal mining positions required heavy manual labor. Because the claimant's symptoms render him unable to walk short distances, climb and carry any significant weight, I find he is incapable of performing his prior coal mine employment.

The Fourth Circuit rule is that "nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis." *Jewell Smokeless Coal Corp. v. Street,* 42 f.3D 241 (4th Cir. 1994). In *Milburn Colliery Co. v. Director, OWCP, [Hicks]*, 21 B.L.R. 2-323, 138 F.3d 524, Case No. 96-2438 (4th Cir. Mar. 6, 1998) *citing Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994), the Court had "rejected the argument that '[a] miner need only establish that he has a total disability, which may be due to pneumoconiosis in combination with nonrespiratory and nonpulmonary impairments." Even if it is determined that claimant suffers from a totally disabling respiratory condition, he "will not be eligible for benefits if he would have been totally disabled to the same degree because of his other health problems." *Id.* at 534.

Three of the physicians of record agree that, in an untreated state, the claimant suffers from a totally disabling respiratory impairment. (DX 23; EX 1 and 5). Dr. Ranavaya does not believe that the claimant's pulmonary impairment would render him unable to perform the duties of his last coal mine job. (DX 11). Where the remaining physicians differ is whether the claimant's respiratory impairment can be treated to render him able to return to his prior employment.

Dr. Baker found that the claimant suffers from a moderate impairment as a result of CWP that would render him unable to return to his previous employment. (DX 23). Drs. Zaldivar and Crisalli both believe that with proper treatment for the claimant's asthma, he would be able to return to his prior employment. With that being said, without the treatment that Drs. Zaldivar and Crisalli recommend, the claimant is totally disabled from returning to his previous coal mining job or a job requiring similar effort. I equate this to a total disability finding. Therefore, I find that the claimant has established by a preponderance of the physician opinion evidence that he currently suffers from a totally disabling respiratory impairment.

Taking all of the evidence together, I find the claimant has met his burden of proof in establishing the existence of total respiratory disability. *Director, OWCP v. Greenwich Collieries [Ondecko]*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994), *aff'g sub. Nom. Greenwich Colleries v. Director, OWCP*, 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

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[27] Opinion that the miner should work in a dust-free environment does not constitute a total disability finding. *See White v. New White Coal Co.*, 22 B.L.R. 1-__, BRB No. 03-0367 BLA (Jan. 22, 2004).

E. Cause of total disability[28]

The revised regulations, 20 C.F.R. § 718.20(c)(1), requires a claimant establish his pneumoconiosis is a "substantially contributing cause" of his totally disabling respiratory or pulmonary disability. The January 19, 2001 changes to 20 C.F.R. § 718.204(c)(1)(i) and (ii), added the words "material" and "materially", results in "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability." 65 Fed. Reg. No. 245, 799946 (Dec. 20, 2000).

The Fourth Circuit Court of Appeals requires that pneumoconiosis be a "contributing cause" of the claimant's total disability.[29] *Toler v. Eastern Associated Coal Co.*, 43 F.3d 109, 112 (4th Cir. 1995); *Jewel Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994). In *Street*, the Court emphasized the steps by which the cause of total disability may be determined by directing "the Administrative Law Judge [to] determine whether [the claimant] suffers from a respiratory or pulmonary impairment that is totally disabling and whether [the claimant's] pneumoconiosis contributes to this disability." *Street*, 42 F.3d 241 at 245.

"A claimant must be totally disabled due to pneumoconiosis and any other respiratory or pulmonary disease, not due to other non-respiratory or non-pulmonary ailments, in order to qualify for benefits." *Beatty v. Danri Corp. & Triangle Enterprises*, 16 B.L.R. 1-11 (1991) *aff'd* 49 F.3d 993 (3d Cir. 1995) *accord Jewell Smokeless Coal Corp.* So, one whose disability is only 10% attributable to pneumoconiosis would be unable to recover benefits if his completely unrelated physical problems (i.e., stroke) created 90% of his total disability.

There is evidence of record that claimant's respiratory disability is due, in part, to his undisputed history of cigarette smoking.[30] However, to qualify for Black Lung benefits, the claimant need not prove that pneumoconiosis is the "sole" or "direct" cause of his respiratory disability, but rather that it has contributed to his disability. *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 914 F.2d 35, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-76. *Jones v. Badger Coal Co.*, 21 B.L.R. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*). There is no requirement that doctors "specifically apportion the effects of the miner's smoking and his dust exposure in coal mine employment upon the miner's condition." *Jones v. Badger*

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[28] *Billings v. Harlan #4 Coal Co.*, ___ B.L.R. __, BRB No. 94-3721 (June 19, 1997). The Board has held that the issues of total disability and causation are independent; therefore, administrative law judges need not reject a Doctor's opinion on causation simply because the doctor did not consider the claimant's respiratory impairment to be totally disabling.

[29] *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990). Under *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L..R 2-68 at 2-76, 914 F.2d 35 (4th Cir. 1990), the terms "due to," in the statute and regulations, means a "contributing cause," not "exclusively due to." In *Roberts v. West Virginia C.W.P. Fund & Director, OWCP*, 74 F.3d 1233 (1996 WL 13850)(4th Cir. 1996)(Unpublished), the Court stated, "So long as pneumoconiosis is a 'contributing' cause, it need not be a 'significant' or 'substantial' cause." *Id.*

[30] *Sewell Coal Co. v. Director, OWCP [O'Dell]* (Unpublished), 22 B.L.R. 2-213, No. 00-2253 (4th Cir. July 26, 2001)(Unpublished). "…the mere documentation of a smoking history on the official OWCP form or elsewhere, without more, cannot reasonably imply that an examining physician has 'addressed the possibility that cigarette smoking caused the claimant's disability." *Malcomb v. Island Creek Coal Co.*, 15 F.3d 364 at 371 (4th Cir. 1994).

Coal Co., 21 B.L.R. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*) *citing generally, Gorzalka v. Big Horn Coal Co.*, 16 B.L.R. 1-48 (1990).[31]

If the claimant would have been disabled to the same degree and by the same time in his life had he never been a miner, then benefits cannot be awarded. *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Pickands Mather & Co.*, 914 F.2d 35, 38 (4th Cir. 1990).[32]

I give greater credit to the opinions of Drs. Baker and Ranavaya finding coal mine dust exposure is the cause of the miner's pneumoconiosis, as their opinions are better supported by the positive x-rays and are more consistent with the miner's 17-years or more of coal mine dust exposure as well as his reported symptoms. Like Drs. Crisalli and Zaldivar, Drs. Baker and Ranavaya account for the miner's extensive smoking history. While they attribute some of his respiratory affliction to smoking, which is consistent with the evidence, they attribute his clinical pneumoconiosis to coal mine dust exposure. Drs. Crisalli and Zaldivar did not find clinical pneumoconiosis and there is no reason to afford their opinions regarding the source of the miner's disability credit. I find that the claimant has established that pneumoconiosis is a contributing cause to his totally disabling respiratory impairment.

ONSET DATE[33]

Benefits are payable beginning with the month of the onset of total disability due to pneumoconiosis.[34] 20 C.F.R. § 725.503. Given Dr. Ranavaya's AGS and PFS results in 2002 were non-qualifying, and that the PFS results did not become uniformly qualifying until Dr.

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[31] *Gross v. Dominion Coal Corp.,* 23 B.L.R. 1-8, BRB No. 03-0118 (2003). Where physician explained that both CWP and smoking were known to cause the type of airflow limitations detected in the miner's lungs and that his totally disabling respiratory impairment was due to both 25 years coal mine dust exposure and 29 years smoking, substantial evidence supported ALJ's finding the doctor gave a well-reasoned opinion the miner was totally disabled due to CWP pursuant to revised 20 C.F.R. 718.204(c). "'The substantially contributing cause' standard of revised Section 718.204(c) was not intended to alter the meaning of 'total disability due to pneumoconiosis' as previously determined in decisions by the various United States Courts of Appeal under Part 718, but rather was intended to codify the courts' decisions. 65 Fed. Reg. at 79946-47. Under the existing law of the Fourth Circuit, claimant is not required to establish relative degrees of causal contribution by pneumoconiosis and smoking to demonstrate that his total disability is due to pneumoconiosis. See *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 at 2-76, 914 F.2d 35 (CA4 1990)(holding that a claimant must prove that pneumoconiosis is at least a contributing cause of total disability). Pneumoconiosis must be a necessary condition of the claimant's disability in that it cannot play a merely de minimis role. *Dehue Coal Co. v. Ballard*, 65 F.3d 1189, 1196 n.8, 19 B.L.R. 2-304, 2-320 n.8 (4th Cir. 1995)." (Fn 10, at 1-18) "Consequently, the revised regulation requires that the adverse effect of pneumoconiosis be 'material.'"

[32] "By adopting the 'necessary condition' analysis of the Seventh Circuit in *Robinson*, we addressed those claim…in which pneumoconiosis has played only a *de minimis* part. *Robinson*, 914 F.2d at 38, n. 5." *Dehue Coal Co. v. Ballard*, 65 F.3d 1189, 1195 n. 8 (4th Cir. 1995).

[33] 20 C.F.R. § 725.503(g) provides: "Each decision and order awarding benefits shall indicate the month from which benefits are payable to the eligible claimant."

[34] The date of the first medical evidence of record indicating total disability does not establish the onset date; rather, such evidence only indicates that the miner became totally disabled at some prior point in time. *Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1984); *Hall v. Consolidation Coal Co.*, 6 B.L.R. 1-1310 (1984). In *Cannelton Industries, Inc. v. Director, OWCP[Frye],* Case No. 03-1232 (4th Cir. April 5, 2004), the Court affirmed ALJ's use of "0/1" readings between 1986 and 1996 to find opacities present (not CWP) and support an onset date by 1997 when an x-ray produced a category 1 interpretation.

Baker's testing, in February 2003, I find the miner did not become totally disabled until that time. Thus, benefits will begin on the first day of that month, February 1, 2003. 20 C.F.R. § 725.503(b).[35]

ATTORNEY FEES

The award of attorney's fees, under the Act, is permitted in cases in which the claimant is found to be entitled to the receipt of benefits. The claimant has thirty (30) days to submit a fee petition. Counsels' attention is directed to 20 C.F.R. §§ 725.365-725.366. A service sheet showing that service has been made upon all the parties, including the claimant, must accompany the application. Parties have ten days following receipt of any such application within which to file any objections. The Act prohibits charging a fee in the absence of an approved application.

CONCLUSIONS

In conclusion, the claimant has established he suffers from pneumoconiosis arising out of his coal mine employment, as defined by the Act and Regulations. The claimant is totally disabled and has established his total disability is due to pneumoconiosis. He is therefore entitled to benefits.

ORDER[36]

It is ordered that the claim of JIMMY BROWNING for benefits under the Black Lung Benefits Act is hereby APPROVED. The employer shall repay any benefits thus far paid by the Director. February 1, 2003 is the effective date of benefits.

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RICHARD A. MORGAN
Administrative Law Judge

[35] *Dempsey v. Sewell Coal Co. & Director, OWCP,* __ B.L.R. ____, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004). ALJ merely concluded, in general terms, that the evidence did not establish an exact date of onset of total disability. This was error. In determining the onset date, the Administrative Law Judge must consider all relevant evidence of record and assess the credibility of that evidence. *Lykins, supra* at 1-183.

[36] § 725.478 Filing and service of decision and order (Change effective Jan. 19, 2001). Upon receipt of a decision and order by the DCMWC, the decision and order shall be considered to be filed in the office of the district director, and shall become effective on that date.

NOTICE OF APPEAL RIGHTS (Effective Jan. 19, 2001): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, i.e., at the expiration of thirty (30) days after "filing" (or receipt by) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, "DCMWC"), by filing a Notice of Appeal with the Benefits Review Board, ATTN: Clerk of the Board, P.O.

[37] 20 C.F.R. § 725.479 (Change effective Jan. 19, 2001). (d) Regardless of any defect in service, actual receipt of the decision is sufficient to commence the 30-day period for requesting reconsideration or appealing the decision.